PRENATAL CARE ASSISTANCE PROGRAM

PCAP

BILLING GUIDELINES

Developed by Computer Sciences Corporation (CSC)

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Prenatal Care Assistance Program

PCAP Questions and Answers

- **What is PCAP?**
  PCAP is the **P**renatal **C**are **A**ssistance **P**rogram. It is a preferred provider model within the NYS Medicaid program. PCAP providers deliver quality, comprehensive prenatal care services to low-income uninsured and underinsured women. The comprehensive services that are reimbursed by Medicaid at an enhanced rate include the following:
  - Obtaining Medicaid for eligible women/presumptive eligibility
  - Outreach to improve early entry into prenatal care
  - Risk assessment
  - Care Planning and Coordination of Care
  - Nutrition Services including enrollment in WIC
  - Psychosocial Services
  - HIV Counseling and Testing
  - Prenatal Diagnostic and Treatment Services
  - Health education
  - Internal Quality Assurance
  - Postpartum Services

- **Who are PCAPs?**
  PCAPs are Article 28 approved hospital outpatient departments or free-standing diagnostic and treatment centers that have submitted an application to the Department of Health demonstrating their ability to provide prenatal care in accordance with part 85.40 of Public Health Law 10 NYCRR. Prenatal care must be listed on the facility's operating certificate for the site(s) where the services will be rendered.

- **Who is eligible for PCAP?**
  Pregnant women with incomes up to 200% of federal poverty level are eligible for Medicaid until at least 60 - 90 days postpartum. These women can receive care at PCAP sites throughout New York State.

MEDICAID (ANNUAL AND MONTHLY) INCOME LEVELS
FOR PREGNANT WOMEN AND CHILDREN

JANUARY 1, 2005

Household Size	Two	Three	Four	Five	Six	Seven	Eight	Each Additional Person
100%	$12,830	$16,090	$19,350	$22,610	$25,870	$29,130	$32,390	+$3,260
FPL	**$ 1,070**	**$ 1,341**	**$ 1,613**	**$ 1,885**	**$ 2,156**	**$ 2,428**	**$ 2,700**	**+$ 272**
133%	$17,064	$21,400	$25,736	$30,072	$34,408	$38,743	$43,079	+$4,336
FPL	**$ 1,422**	**$ 1,784**	**$ 2,145**	**$ 2,506**	**$ 2,868**	**$ 3,229**	**$ 3,590**	**+$ 362**
200%	$25,660	$32,180	$38,700	$45,220	$51,740	$58,260	$64,780	+$6,520
FPL	**$ 2,139**	**$ 2,682**	**$ 3,225**	**$ 3,769**	**$ 4,312**	**$ 4,855**	**$ 5,399**	**+ 544**

- A pregnant woman counts as two.
- Children under 1 year eligible at 200%.
- Children 1-5 years are eligible at 133%.
- Children 6-18 years are eligible at 100%, effective April 1, 2005.

Revised February 23, 2005

- **How are PCAPS reimbursed for care provided?**
  PCAPs are reimbursed at an enhanced rate through Medicaid using three (3) discrete rate codes:

  - Initial Visit
  - Subsequent Visit
  - Postpartum Visit

- **What are the PCAP Rate Codes?**

SERVICE TYPE	HOSPITAL- BASED CLINIC CATEGORY OF SERVICE **0287** RATE CODE	FREE STANDING CLINIC CATEGORY OF SERVICE **0160** RATE CODE
Initial Patient Visit	3101	1601
Follow-up Visit	3102	1602
Postpartum Visit	3103	1603

PCAP CLINIC SPECIALITY CODES *	
Specialty Code	**Specialty Description**
904	Obstetric
905	Gynecology
906	Family Planning
914	General Medicine

***Clinic must be enrolled with the specialty code to bill using one of the above listed codes.**

Note: Payment for services rendered is based on a discrete rate established by the State Department of Health.

➢ What is included in the PCAP Initial Visit Rate Code?

INITIAL VISIT

- Only **one** initial prenatal visit may be billed per pregnancy regardless of the number of visits it takes to complete all the components.

- All services associated with the initial visit must be completed within 60 days.

This visit shall include:

- Medicaid presumptive eligibility determination
- A complete history and physical examination, and pelvic examination
- Risk assessment, including medical and psychosocial factors
- Laboratory screening
- Prenatal genetic risk screening
- Initiation of patient education
- Initial development of a care plan
- Screening for nutritional and psychosocial risk factors with appropriate referrals
- HIV counseling and testing

➢ Can the Initial Prenatal evaluation or visit be conducted in more than one encounter*?*

Yes, but only one PCAP Initial Visit rate code may be submitted to Medicaid. If all components of the initial prenatal evaluation as stated in the PCAP Provider Agreement, appendix 2 (rev. 4/9/02), Clinic Services Description, cannot be scheduled on the same day, an intake or triage visit may be conducted prior to the medical evaluation. This intake or triage visit cannot be billed as a PCAP subsequent visit rate code. **A PCAP Initial Visit rate code can only be billed after all components, as stated in the PCAP Appendix 2, have been completed regardless of the number of encounters involved.**

➢ What is meant by presumptive eligibility (PE)?

Presumptive eligibility (PE) is the process where a preliminary financial screen for a pregnant woman is conducted at the PCAP site by a qualified provider (QP) to determine if the woman is financially eligible for Medicaid (0-200% of the Federal Poverty Level). If the pregnant woman is determined to be presumptively eligible for Medicaid, PCAPs are able to begin the woman's care, and are guaranteed to be paid for services rendered until the application is processed and a full determination of Medicaid eligibility is made, even if the final determination is a denial. The PE period commonly lasts for 45-60 days.

➢ Does a PCAP have to conduct Presumptive Eligibility screening?

Yes. Appendix 1 of the PCAP Comprehensive Agreement stipulates that all PCAPs conduct presumptive eligibility screenings. All PCAPs must receive training to become a qualified provider to conduct PE. Qualified providers receive special training from the Local Departments of Social Services or HRA in NYC. To obtain this training contact:

☎ Upstate - phone numbers for County's Local Department of Social Services are listed in white pages of phone book or

Access DOH web site:
http://www.health.state.ny.us/nysdoh/medicaid/ldss.htm

☎ NYC (212) 273-0047

The training includes a CD-ROM on completion of the presumptive eligibility determination and the Growing Up Healthy Medicaid application.

The PCAP is able to assist the woman in assembling the necessary paperwork for a full Medicaid application and conveys the information to the local Medicaid office. This process eliminates the need for the woman to make a separate trip to the local DSS office to complete the application.

➢ What is included in the PCAP Subsequent Visit?

PRENATAL FOLLOW UP VISITS

These visits shall be for the purpose of providing on-going prenatal care and shall include the following components:

On-going risk assessment:
Review of symptoms including headache, changes in vision, dizziness, edema, nausea and vomiting, bleeding; and awareness of fetal movements, occurrence of contractions or rupture of membranes; review of laboratory data; and review of emerging medical and psychosocial factors with appropriate documentation in the care plan and referral when indicated.

Physical examination:
Maternal blood pressure, weight, presence of edema, height of fundus, fetal position and heart beat.

Recommended Laboratory Tests and other Procedures:

- Urine testing for sugar and albumin at each visit,
- Glucose challenge test at 28 weeks
- Repeat gonorrhea, chlamydia and syphilis screen during 3rd trimester, as clinically indicated
- Repeat hematocrit or hemoglobin at 36 weeks
- Urinalysis and urine culture as needed
- Group B streptococcus culture at 35-37 weeks, as indicated per CDC guidelines
- Obsetrical ultrasound, as clinically indicated
- Rh titre, as indicated

Health Education*:*
Health education shall be documented in the medical record and include the following topics:

- Orientation to facility procedures
- Rights/responsibilities of the pregnant women
- Signs of complications of pregnancy
- Physical activity and exercise during pregnancy
- Avoidance of harmful practices and substances including alcohol, drugs, non-prescribed medications, and nicotine
- Sexuality during pregnancy
- Occupational concerns
- Risks of HIV infection and risk reduction behaviors
- Signs of labor

- Labor and delivery process
- Relaxation techniques in labor
- Obstetrical anesthesia and analgesia
- Preparation for parenting including infant development, care and options for feeding
- Orientation to expanded Medicaid eligibility for infants up to one year of age
- The newborn screening program with distribution of newborn screening educational literature
- Family planning

Additional Information About Prenatal Follow Up Visits

- No limit to the number of follow-up visits that may be billed

- Follow-up visits must include an assessment by a licensed prenatal provider (MD, midwife, nurse practitioner or physician's assistant) for a PCAP rate code to be billed

- HIV post-test counseling should be provided for those clients who were HIV tested

- Follow-up visits must not be billed with a service date after the date of delivery

- **Is there a limit to the number of PCAP Subsequent Visits that can be billed?**

There is no limit to the number of Subsequent Visits that a PCAP may bill. However, all Subsequent Visits must be necessary and appropriate to the plan of care and must include a physical assessment and determination of ongoing risk by a medical practitioner as stated above. For example, if a PCAP client is seen by a nurse, nutritionist and/or a social worker and there is no medical provider encounter, a PCAP rate code cannot be billed. Also, a telephone visit would not constitute a billable PCAP visit.

- **How are Non Stress Tests (NST) and Biophysical Profiles (BPP) billed?**

A non stress test and/or biophysical profile performed on the same date of service as a prenatal follow-up visit is part of the PCAP follow-up visit rate and may not be billed separately. If these tests are performed on a date of service other than a scheduled prenatal follow-up visit, the PCAP follow-up visit rate code may be billed only if all components of the prenatal follow-up visits are rendered.

- **How are HIV Counseling and Testing Services billed by the PCAP if provided on the same date of service as a PCAP visit?**

If the Article 28 PCAP has signed the HIV Primary Care Provider Agreement, the agency can bill for HIV services on the same date of service as a PCAP encounter using the appropriate HIV rate codes. Otherwise, no separate reimbursement is allowed.

- **If a PCAP client needs to be referred to a specialist, how is that billed?**

  If a PCAP client is referred to a specialist such as a perinatologist, the specialist should bill according to his/her usual practice when billing Medicaid. The method of billing would depend on whether the specialist is salaried for professional services by an Article 28 facility or is in a private office setting. For example, if the client is seen in a clinic, and the facility has reported the costs of providing these services to DOH for the purposes of clinic rate calculation, then a Medicaid clinic rate should be billed. If services are rendered in a private office setting, the MMIS physician's procedure codes should be billed.

- **Is there any reimbursement for fetal monitoring provided to PCAP clients?**

  There is no separate reimbursement for fetal monitoring as that is considered to be part of the inpatient DRG rate.

- **What is included in a Postpartum Visit rate code?**

  POSTPARTUM CARE

  - Only one postpartum visit can be billed
  - Includes a two-week incision examination following a Cesarean section.
  - Payment for a postpartum visit is for providing care for a period of up to 60 days following delivery
  - Following delivery, if additional visits are necessary due to medical complications, claims should be submitted with the clinic's general medicine rate codes

The Postpartum Visit is for the purpose of providing postpartum care for a period up to 60 days following delivery. A postpartum visit should occur between 4-8 weeks after delivery, depending upon the individual needs of the client and shall include the following components:

- ***On-going risk assessment:*** Review medical, psychosocial, nutritional, alcohol treatment, drug treatment and educational needs of the mother, infant and family with appropriate referral when indicated

- ***Physical examination:*** Assessment of the breast, blood pressure, abdomen, external and internal genitalia and weight

- ***Laboratory Studies:*** Complete blood count and other tests as indicated

- ***Health Education:*** A combination of private interviews with health personnel, group discussions or classes, and printed material in the client's native language. Health education should be documented in the medical record and should include the following topics:
  - Methods of Family Planning
  - Preconception Counseling Needs
  - Care of the infant, including infant feeding and pediatric follow-up
  - Prevention of HIV and Sexually Transmitted Diseases
  - Physical activity and exercise
  - Nutrition
  - Infant development
  - Expanded Medicaid eligibility for infants up to age one

- ***Family planning*****:** Assess family planning needs and provide advice and service or referral where indicated

- ***Preconception Counseling***

- ***Pediatric Follow-up***

- **Can genetic services be separately billed to Medicaid for PCAP clients?**

  Yes. The billing should be done using one of the following methods: clinic, physician/laboratory or ambulatory surgery rates. Each agency's fiscal officer should determine which of the above methods is used. The determination is based on how the facility aggregated and reported costs of operating these genetic services to the Department of Health. If costs have been incorporated into the clinic rate calculation, clinic or ambulatory surgery rates should be billed. If not part of the above rates, MMIS fee for service codes (physician/laboratory) are to be utilized.

- **Are Level II and III sonograms considered part of the PCAP rate?**

  Yes. All sonograms (levels I - III) are included in the PCAP bundled rate and cannot be billed separately.

- **If a physician is under subcontract with a PCAP, can deliveries be billed separately?**

  Yes. Deliveries (vaginal or c-section) can be billed by the physician or licensed midwife using appropriate MMIS codes listed in the procedure section of the MMIS provider manual. All antepartum and postpartum visits are included in the PCAP rate and cannot be separately billed to Medicaid by the physician or licensed midwife.

- **If a woman presents to the PCAP with a medical condition during the prenatal period, i.e., strep throat, can the PCAP program bill a PCAP visit rate code?**

  A PCAP subsequent visit rate code can only be billed if all components of a PCAP subsequent visit are rendered. If a pregnant woman is seen in the office or clinic solely to treat a medical condition, such as strep throat, a PCAP visit cannot be billed.

➢ If a woman is enrolled in Medicaid Managed Care during the course of her prenatal care can PCAP rate codes be billed?

PCAP rate codes can be billed for visits that took place *prior* to enrollment in the managed care plan. PCAP staff should check eligibility using the Electronic Medicaid Eligibility Verification System (EMEVS) prior to each visit to assure that the woman has not been enrolled in a managed care plan since her last visit. All services provided to the patient should meet prenatal standards (85.40 10NYCRR) regardless of payer.

➢ Are PCAP visits exempt from Utilization Thresholds (UT's)?

Yes. PCAP rate codes are exempt from UT's.

SERVICES NOT INCLUDED IN PCAP RATES

➢ What services are not included in the PCAP rates?

PCAP rates do ***not*** include reimbursement for the following services:

- Pharmaceuticals
- Drug Treatment and Screening Services
- Genetic Services including Amniocentesis, Chromosome Analysis and Physician/Geneticist Evaluation
- Mental Health Services
- Transportation Services
- Inpatient Care
- Specialty Physician and Clinic Services
- Labor and Delivery Services
- Dental Services
- Emergency Room Services
- Home Care
- HIV Services
  *If the Article 28 PCAP has signed the HIV Provider Agreement, the clinic can bill for HIV services on the same date of service as a PCAP encounter using the appropriate HIV rate codes.

Note: Routine Medicaid rates or fee-for-service procedures codes should be used to obtain reimbursement for services not included in PCAP rate.

PCAP ARTICLE 28 CLINICS

PCAP CLINIC SPECIALTY CODES	
Obstetrics	**904**
Gynecology	**905**
Family Planning	**906**
General Medicine	**914**
*** Article 28 PCAP Clinics must be enrolled with specialty code in order to bill Medicaid using one of the above listed codes.**	

HOSPITAL BASED Category of Service 0287	
SERVICE TYPE	**RATE CODE**
Initial Prenatal Visit	3101
Follow – Up Visit	3102
Postpartum Visit	3103

FREE STANDING Category of Service 0160	
SERVICE TYPE	**RATE CODE**
Initial Prenatal Visit	1601
Follow – Up Visit	1602
Postpartum Visit	1603

"PAY AND SEEK" REMINDERS"

➢ What is "Pay and Seek?"

NYS DOH's policy has been modified due to Federal legislation regarding billing third party insurance for certain prenatal services and preventative pediatric care. Under the "Pay and Seek" guidelines, Article 28 clinics or fee-for-service physicians, nurse practitioners and licensed midwives are *not* required to seek reimbursement from third party insurers prior to billing Medicaid. Providers may bill Medicaid before billing other insurers for certain prenatal and pediatric services identified with an ICD-9-CM diagnosis code* that falls within the range of the "pay and seek" guidelines. Payment for "pay and seek" claims will be at the Article 28 clinic's rate, or the lower of either the NYS maximum allowable fee-for-service or the practitioner's usual and customary charge. The Department of Health will collect any monies due from the responsible third party insurer.

➢ What services can be billed under the "Pay and Seek" system?

Services that can be billed under "Pay and Seek" include:

- Certain ambulatory prenatal services, and
- Certain ambulatory preventative pediatric care

➢ Does Medicaid require any special billing information*?*

Yes. Claims must be submitted with an ICD-9-CM diagnosis code that falls within the scope of the "Pay and Seek" guidelines.*

Note: "Pay and Seek" is optional. Providers may continue to bill a recipient's third party insurer before seeking Medicaid.

*"Pay and Seek" Diagnosis Codes appear on pages 15 and 16.

"PAY AND SEEK"
PRENATAL CARE SERVICE
ICD-9-CM DIAGNOSIS CODES

PRENATAL CARE is defined as services provided to pregnant women if such services relate to the pregnancy or to any other medical condition that may complicate the pregnancy. The types of claims include:

- Routine Prenatal Care,
- Prenatal Screening for Mother or Fetus,
- Care provided in the Prenatal Period to the Mother for Complications of Pregnancy.

ICD-9-CM Diagnosis Codes	Description
V22.0 V22.1	Supervision of normal pregnancy
V23.0 - V23.9	Supervision of high risk pregnancy
V28.0 - V28.9	Antenatal Screening
* 640.0 - 648.9	Complications related to pregnancy
651.0 - 658.9 671.0 - 671.9 673.0 - 673.8 675.0 - 676.9	Other conditions requiring care in pregnancy

* Claims qualify for "pay and seek" reimbursement only if the fifth digit is a 3.

"PAY AND SEEK"
PREVENTATIVE PEDIATRIC CARE
ICD-9-CM DIAGNOSIS CODES

PREVENTATIVE PEDIATRIC CARE is defined as screening and diagnostic services to identify congenital physical or mental disorders, routine examinations performed in the absence of complaints, screening or treatment designed to avert various infectious and communicable diseases from ever occurring in children under 21. Services include:

- Immunizations
- Screening Tests for Congenital Disorders
- Well Child Visits, Preventative Medicine Visits
- Preventative Dental Care
- Screening and Preventative Treatment for Infectious and Communicable Diseases.

ICD-9-CMCode	Description	Immunizations	Screening Tests for Congenital Disorders	Well Child Preventative Medicine Visits	Preventative Dental Care	Screening or Preventative Treatment for Infections and Communicable Diseases
V01.0 - V01.9	Contact with or exposure to a communicable disease.					X
V02.0 - V02.9	Carrier or suspected carrier of infectious disease					X
V03.0-V06.9	Need for prophylactic vaccination against bacterial viral and communicable diseases	X				X
V07.0 – V07.9	Need for isolation and other prophylactic measures	X				X
V20.0 - V20.2	Health supervision of infant and child			X		
V70.0	Routine general medical examination			X		
V72.0 - V72.3	Routine examination of specific organ system			X		
V73.0 -V75.9 V77.0 - V77.7 V78.2 - V78.3 V79.2 - V79.3 V79.8 V82.3 - V82.4	Special screening exams or tests for infectious and communicable diseases or congenital defects		X			X

➢ Where can I find additional information on PCAP?

- General information questions should be directed to:

  Bureau of Women's Health
  Perinatal Health Unit
  New York State Department of Health
  Empire State Plaza
  Corning Tower- Room 1882
  Albany New York 12237
  518-474-1911

- Questions about billing procedures should be directed to:

  Computer Sciences Corporation
  Practitioner Services
  1-800-343-9000

- Questions about policy, related to the PCAP program, should be directed to:

  New York State Department of Health
  Office of Medicaid Management
  518-486-6562

  OR

Access the New York State Department of Health's website at:
http://www.health.state.ny.us/nysdoh/perinatal/en/pcap.htm

Information on the following topics can be obtained at the above website:

🗁 Prenatal Care Assistance Program
🗁 Guidance for Prenatal Standards (85-40 Regulations)
🗁 PCAP Services Description
🗁 Guidance for Submission of an Application for Designation as a Provider under PCAP
🗁 Application for Comprehensive Prenatal Care Service Provider Participation
🗁 Application for Additional PCAP sites
🗁 Prenatal Care Assistance Program Annual Report
🗁 Instructions for Completing the PCAP Annual Report
🗁 Medicaid Income Levels for Children and Pregnant Women
🗁 Prenatal Care Assistance Program Billing Guidelines in PDF format
🗁 Medicaid PCAP Rates by Trend Factor
🗁 Find a PCAP Provider Near You